August 31, 2018

Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 20201

RE: CMS-1689-P, Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations; Proposed Rule (Federal Register, Vol. 83, No. 134, July 12, 2018)

Dear Ms. Verma:

On behalf of our 39 member hospital-based home health agencies, the Illinois Health and Hospital Association (IHA) takes this opportunity to formally comment on the proposed rule establishing new policies and payment rates for Medicare home health services for calendar year (CY) 2019. The proposed rule contains two policies that raise concerns and for which we are presenting comments: the proposed change in the methodology for computing the rural add-on payments and the proposed Patient Driven Groupings Model:

- **Change in the Methodology for Computing the Rural Add-On Payment:** In accordance with the Bipartisan Budget Act of 2018, CMS proposes to revise the methodology for calculating the payment percentage increase that is currently being given (3 percent) to rural home health agencies. Beginning in CY 2019 through CY 2022, the percentage add-on will be based on the classification of the county in which the agency is located: high utilization; low population density; or all other. IHA has two concerns with the CMS' implementation of the law:

  First, IHA notes that the percentage add-on steadily decreases for all three of these county classifications over the four-year period, resulting in a 0 percent add-on for the “high utilization” and “other” county categories in CY 2022 and only a 1 percent add-on for the low utilization county in that same year. IHA is concerned that over time, our rural home health agency members will incur significant losses as the add-on percentage decreases. We ask that CMS provide the statutory authority for its implementation of these specific decreases and if allowed under...
current law, to increase the percentages of the add-on for the four-year period that are presented in the proposed rule.

Second, CMS has proposed that once an agency is classified in one of the three categories, it retains that classification throughout the entire four-year period. **IHA disagrees with this approach as it is inconsistent with the process used to calculate wage indices under various prospective payment systems.** Providers are currently permitted to seek geographic reclassifications to other Core-Based Statistical Areas (CBSAs) based on changes in their own (or their location’s) demographics. If demographics change, providers are also able to retract those reclassifications. Because of ongoing population changes, a county’s classification as “low population density” may not be appropriate over an entire four-year period.

Also, CMS points out that in determining the high utilization classification, it relies on Medicare episode data *excluding* Medicare Advantage Plan services. Illinois and the U.S. have seen steady increases in the percentage of Medicare beneficiaries enrolled in these plans. Therefore, the resulting change in the Medicare fee-for-service episodes composition of the high percentage category could be significant, resulting in the need for counties currently classified as “high utilization” (and their agencies) to be changed to another category. **IHA recommends that CMS develop criteria in which counties would be moved from one classification category to another.**

- **Implementation of the Patient-Driven Groupings Model (PDGM):** In the CY 2019 proposed rule, CMS provides more information concerning its Patient-Driven Groupings Model that will be implemented in CY 2020, as legislated by the Bipartisan Budget Act of 2018. IHA supports a payment system that will be more driven by patient needs than volume, but is concerned that the model’s detailed specifications as presented in the rule will place increased administrative burdens on agencies, particularly in the area of “split percentage” payments. **Therefore, IHA recommends that CMS discuss in the final rule how the agency will provide education and resources to help home health providers adapt to the new model.**

Ms. Verma, thank you again for the opportunity to comment. If you or your staff has any questions on the comments, they should be addressed to Thomas Jendro at 630-276-5516 or tjendro@team-iha.org.

Sincerely,

A.J. Wilhelmi
President & CEO